STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 00 B. WING	09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 19, 20, 21, 22, & 23 2011 Facility number: 000167 Provider number: 155266 AIM number: 100273740 Survey team: Rick Blain, RN TC Sue Brooker, RD Sheryl Roth, RN Angela Strass, RN Census bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 11 Medicaid: 58 Other: 8 Total: 77 Stage 2 sample: 34 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 9/28/11	F0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state of deficiencies. The plan of correction is prepared and/or executed because it is required by the provisions of federal and state law. We respectfully request the ISDH accept paper compliance as evidence of compliance with federal requirements for participation in the Medicare and/or Medicaid programs in place of a revisit survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Cathy Emswiller RN			
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review the facility failed to include 1 of 3 sampled residents (Resident #67) in group activities of the 10 residents who met the criteria for activities. Findings include: Review of the clinical record for Resident #67 on 9/21/11 at 9:25 a.m., indicated the following: diagnoses included, but were not limited to, Down's Syndrome and presenile delirium. A family member of Resident #67 was interviewed on 9/20/11 at 11:08 a.m. During the interview she indicated Resident #67 was not taken to activities due to her behavior. An Activity Progress Notes for Resident #67, dated 4/17/11, indicated she passively attended group activities such as Bingo, Pokeno, morning stretch, dining room bowling, religious services, bible study, games of choice and women's group. The Progress Notes also indicated	F0248	**F 248 Activities Meet Interests/Needs of Each Res** ·Resident (#67) was reassessed by Activities Director and now involved in group activities of choice. ·An assessment of every residents last change of condition was completed on 10/10/11 by the Activities Director. ·Weekly Activities staff meetings initiated to relay information. Activity Aides were in-serviced on 10/7/11 by the Executive Director of the need to assist resident (#67) to group activities. Quarterly assessments of charts will include interdisciplinary team to ensure care plans are coordinated among departments. ·Activities Director will complete audit of care plans weekly X 90 days to ensure compliance. based on MDS schedule and significant change and report	10/10/2011

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	Resident #67 actively attends sensory group, morning stretch and musical entertainment. The Progress Note further indicated Resident #67 was involved in independent activities such as television, music, and family/friend visit. She required escorts to activities. The most current Activities Evaluation for Resident #67, dated 5/13/10, indicated current activity preferences of animals/pets, arts/crafts, beauty/barber, cards, community outings, educational programs, exercise, family/friend visits, group discussion, movies, music, radio, reading, religious services, religious studies, sing-along, social/parties, television, and walking. A facility Minimum Data Set (MDS) Activity Progress Note for Resident #67, dated 5/24/11, indicated she enjoyed music and television. The Progress Note also indicated Resident #67 attended morning stretch, musical entertainment, special events, arts and crafts and religious services. The Progress Note further indicated Resident #67 was not receiving 1:1 visits at that time. A facility care plan for Resident #67, dated 7/24/11, indicated the problem of resident was often loud and disruptive during activities. Approaches to the		concerns. Findings will be brought to the PI Committee monthly with tracking and trending discussed. A goal of 100% compliance with care planning of activities X90 days will be achieved. Once 100% compliance is achieved, PI Committee will then monitor quarterly to assure continued compliance. ·Date of Completion: 10/10/11	

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	problem included, but were not limited to, give resident opportunity to express opinion of activities attended, offer activity programs directed toward specific interests of resident, transport resident to activities, offer independent activities appropriate to interests such as flash cards, stuffed animals, Spiderman and other small things to hold in her hands, and remove resident from activity if behavior is unacceptable to others. An Activity Progress Notes for Resident #67, dated 8/23/11, indicated she propelled herself via wheelchair and needed escorts to activities. The Activity Progress Notes also indicated Resident #67 passively attended group activities such as morning stretch, arts and crafts, sensory group, cooking group, religious services, women's group and special events/parties. The Progress Note further indicated Resident #67's independent activities included movies, television, friend/family visits, visits from peers and staff, and listening to music. A facility care plan for Resident #67, with a review date of 11/11, indicated the problem for the need of individualized activities. Approaches to the problem included, but were not limited to, sensory stimulation activities will be offered and small sensory groups.			

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	The Activity Director was interviewed on 9/22/11 at 1:56 p.m. During the interview he indicated Resident #67 did not do well with individualized activities and she was to continue with active or passive participation in group activities. He also indicated activity staff were responsible for recording the attendance for Resident #67 on the Individual Resident Daily Participation Record. He further indicated the letter A meant active participation, the letter P meant passive participation, the letter R meant refused, and the letter U meant unable. A facility Activities Schedule for September 2011, provided by the Activity Director on 9/22/11 at 1:56 p.m., indicated the following: on 9/20/11, morning stretch at 9:30 a.m., music with (name documented) at 10:00 a.m., and Bingo at 3:00 p.m.; on 9/21/11, morning stretch at 9:30 a.m., trivia at 11:00 a.m., and dining room basketball at 1:30 p.m.; and 9/22/11, sensory group at 9:30 a.m., chapel at 10:00 a.m., and horseshoes at 2:00 p.m. A facility Individual Resident Daily Participation Record for Resident #67, for the month of September 2011, indicated she actively participated in current events/news on 9/20/11 and on 9/21/11,			

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	passively participated in exercise on 9/20/11, and passively participated in group discussion on 9/20/11 and 9/21/11. The Participation Record also indicated she actively participated in movies, music, radio, and television in her room on 9/20/11 and 9/21/11. The Participation Record did not indicate Resident #67 refused to attend music with (name documented) on 9/20/11 at 10:00 a.m., Bingo on 9/20/11 at 2:00 p.m., and trivia on 9/21/11 at 11:00 a.m. No entries had been made on the Participation Record for 9/22/11. Resident #67 was not observed attending any of the scheduled activities on: 9/20/11, morning stretch at 9:30 a.m., music with (name documented) at 10:00 a.m., and Bingo at 2:00 p.m.; 9/21/11, morning stretch at 9:30 a.m., and trivia at 11:00 a.m.; 9/22/11, sensory group at 9:30 a.m., Thursday Chapel at 10:00 a.m., and horseshoes at 2:00 p.m. Activity Assistant #2 was interviewed on 9/22/11 at 2:17 p.m. During the interview she indicated activity staff were responsible to bring the residents who required assistance with transportation to activities. The Director of Nursing and the Activity Director were interviewed on 9/23/11 at 9:45 a.m. During the interview they indicated Resident #67 had been ill in			

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	June, 2011 and spent most of her time in bed. They also indicated the facility had not re-initiated Resident #67 into group activities since her health had improved. A facility "Resident Admission Agreement", dated 2002, indicated "...The Resident has a right to choose activities...consistent with his or her interests, assessments, and plans of care...." 3.1-33(a)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a care plan for 1 of 3 residents reviewed for dental concerns (Resident #9) in a sample of 9 residents who met the criteria for dental status and services. Findings include: The clinical record for Resident #9 was reviewed on 9/21/11 at 9:30 a.m. Diagnoses included, but were not limited to, high blood pressure, above the knee amputation, muscle weakness and a history of joint replacement. There was no specific care plan related to oral care, teeth, or partial dentures located in the	F0279	**F279 Develop Comprehensive Care Plan** ·Resident (#9) saw the dentist 9/22/11 and currently has no unmet dental needs. ·100% audit will be conducted by 10/23/11 of active medical records by the Director of Nursing or designee to determine any unmet dental needs. ·Licensed nursing personnel will be in-serviced by SDC by 10/23/11 on conducting complete and accurate oral assessments based on the MDS schedule utilizing the Oral Assessment Form and MDS schedule. - Staff Development Coordinator	10/23/2011

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	clinical record during a review of the current care plans. The Minimum Data Set (MDS) Assessment for Resident #9, dated 4/7/11, did not indicate any dental concerns and the dental status did not trigger for care planning. The MDS further indicated the resident did not have any problems with short or long term memory. A dental visit report for Resident #9, dated 4/12/11, indicated the resident had inflammation and plaque and needed to return to the dentist by 7/12/11. The note further indicated the resident needed pre-medication before returning for visit. Oral Assessment Form (3/21/11, 4/5/11, 5/13/11, 7/7/11) indicated Resident #9 had both upper and lower partials. The form was incomplete for which teeth were missing. No particular concerns were noted on the assessment. A nurse's note, dated 4/12/11 at 10:20 p.m., indicated a new order for a medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement. A dental visit report for Resident #9, dated 9/22/11, indicated the resident had 5 fillings (amalgam) completed.		will educate newly hired licensed personnel during orientation on accurate completion of the Oral Assessment Form. - The MDS Coordinator will utilize the Oral Assessment Form and review the resident's dental summary from the last dental visit to ensure accuracy and completeness of the Oral Assessment Form based on MDS schedule. Any inconsistencies or unmet needs will be reported to the physician and Director of Nursing for appropriate follow up. 4. Nursing Administration will be responsible for assuring the accuracy and completeness of Oral Assessment Forms and that all dental needs are care planned appropriately. - Nursing administration will audit 100% of oral assessment forms, dental visits, and dental care plans weekly X 90 days to ensure compliance. Findings will be brought A goal of 100% compliance to the PI committee monthly with tracking and trending discussed. A goal of 100% compliance with care planning dental needs X 90 days will be achieved. Once 100% compliance is achieved, PI Committee will then monitor quarterly to assure continued compliance. 5. Date of Completion: 10/23/11	

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	An interview was conducted with Resident #9 on 9/19/11 at 2:52 p.m. During the interview, she indicated she was having problems with her back teeth, both upper and bottom. 3.1-35(a) 3.1-35(b)(1)			
F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview and record review the facility failed to update	F0280	**F 280 Right to Participate Planning Care for activities. Completed**	10/10/2011

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	the activity care plan of 1 of 3 sampled residents (Resident #67) reviewed for activities of the 10 residents who met the criteria for activities. Findings include: Review of the clinical record for Resident #67 on 9/21/11 at 9:25 a.m., indicated the following: diagnoses included, but were not limited to, Down's Syndrome and presenile delirium. The most current Activities Evaluation for Resident #67, dated 5/13/10, indicated current activity preferences of animals/pets, arts/crafts, beauty/barber, cards, community outings, educational programs, exercise, family/friend visits, group discussion, movies, music, radio, reading, religious services, religious studies, sing-along, social/parties, television, and walking. An Activity Progress Notes for Resident #67, dated 8/23/11, indicated she propelled herself via wheelchair and needed escorts to activities. The Activity Progress Notes also indicated Resident #67 passively attended group activities such as morning stretch, arts and crafts, sensory group, cooking group, religious services, women's group and special events/parties. The Progress Note further		**10/10/11 by Activities Director.** **·Care plans reviewed by the Activities Director for change of condition of resident and appropriate goals and approaches on 10/10/11** **1.Activities Director was reeducated by the Executive Director on 10/3/11 on change of condition, new admissions and quarterly assessments:** **- MDS Coordinator will ensure change of condition is reported to each discipline and changes to care plans are initiated within seven days of change.** **·Quarterly assessments will include an audit of each disciplines care plans by the Activity Director or designee.** **- Activities Director will complete reviews of care plans monthly prior to Process Improvement Meeting and report any issues.** **4. Activities Director will complete audit of care plans based on MDS schedule and significant change and report concerns weekly X 90 days to ensure compliance.** **- Findings will be brought to the PI Committee monthly with tracking and trending discussed. A goal of 100%**	

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	indicated Resident #67's independent activities included movies, television, friend/family visits, visits from peers and staff, and listening to music. A facility care plan for Resident #67, with a review date of 11/11, indicated the problem for the need of individualized activities. Approaches to the problem included, but were not limited to, sensory stimulation activities will be offered and small sensory groups. A facility Activities Schedule for September 2011, provided by the Activity Director on 9/22/11 at 1:56 p.m., indicated the following: on 9/20/11, morning stretch at 9:30 a.m., music with (name documented) at 10:00 a.m., and Bingo at 3:00 p.m.; on 9/21/11, morning stretch at 9:30 a.m., trivia at 11:00 a.m., and dining room basketball at 1:30 p.m.; and 9/22/11, sensory group at 9:30 a.m., chapel at 10:00 a.m., and horseshoes at 2:00 p.m. A facility Individual Resident Daily Participation Record for Resident #67, for the month of September 2011, indicated she actively participated in current events/news on 9/20/11 and on 9/21/11, passively participated in exercise on 9/20/11, and passively participated in group discussion on 9/20/11 and 9/21/11.		**compliance with care planning of activities X90 days will be achieved. Once 100% compliance is achieved, PI Committee will then monitor quarterly to assure continued compliance.** **5. Date of Completion: 10/10/11** ·Resident (#67) has an Interdisciplinary Team Meeting scheduled for 10/17/11 to update activity care plan. ·Residents were reassessed and care plans updated	

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	The Participation Record also indicated she actively participated in movies, music, radio, and television in her room on 9/20/11 and 9/21/11. The Participation Record did not indicate Resident #67 refused to attend music with (name documented) on 9/20/11 at 10:00 a.m., Bingo on 9/20/11 at 2:00 p.m., and trivia on 9/21/11 at 11:00 a.m. No entries had been made on the Participation Record for 9/22/11. Resident #67 was not observed attending any of the scheduled activities on: 9/20/11, morning stretch at 9:30 a.m., music with (name documented) at 10:00 a.m., and Bingo at 2:00 p.m.; 9/21/11, morning stretch at 9:30 a.m., and trivia at 11:00 a.m.; 9/22/11, sensory group at 9:30 a.m., Thursday Chapel at 10:00 a.m., and horseshoes at 2:00 p.m. Resident #67 did not receive any individualized activities during this time. The Activity Director was interviewed on 9/22/11 at 1:56 p.m. During the interview he indicated Resident #67 did not do well with individualized activities and she was to continue with active or passive participation in group activities. The activity care plan did not reflect the change. A current facility policy " Resident Care Plan", revised 12/08, indicated "...Review of the care plan is done at least quarterly			

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	and as needed to reflect the resident's current needs, problems, goals, care, treatment, and services...." 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure pain assessment follow up was completed for PRN meds as care planned for 1 of 3 residents reviewed for pain (Resident #9) in a sample of 6 residents who met the criteria for pain recognition and management .	F0282	**F282 Services by Qualified Persons/Per Care Plan** **- Health Information Manager will audit Medication Administration Record books with monthly Medication Record change out to assure Pain Flow Sheets are placed in the Medication**	10/23/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: The clinical record for Resident #9 was reviewed on 9/21/11 at 9:30 a.m. Diagnoses included, but were not limited to, high blood pressure, above the knee amputation, muscle weakness and a history of joint replacement. The PRN (as needed) Medication Administration Record (MAR) for June 2011, indicated there was an order for acetaminophen (pain reliever) to be given every four hours as needed for pain. The order indicated staff was to document on the pain flow sheet. The MAR indicated Resident #9 had received the pain medication on 6/8/11 at 11:00 a.m. There was no documentation on the flow sheet to indicate the location of pain or the intensity of the pain. The PRN MAR for June 2011, indicated there was an order for ultram (pain reliever) to be given three times a day as needed for pain. The order further indicated staff was to document on the pain flow sheet. The record indicated Resident #9 had received the pain medication on 6/8/11 at 1:10 p.m., 6/15/11 at 1:55 p.m., and 6/22/11 at 11:00 a.m. There was no documentation regarding the location of pain, intensity of		**Administration Books. Residents that are started on as needed pain medications within the month will be identified by physician's orders and the DON or designee will assure a Pain Flow Sheet is implemented by performing - Twice weekly a 100% audit of Pain Flow Sheets to assure the forms are being utilized correctly. The DON will review audits weekly and provide further education and/or disciplinary action as needed. - Findings will be brought to the PI Committee monthly with tracking and trending discussed. A goal of 100% compliance with correct utilization of the Pain Flow Sheet X 90 days will be achieved. Once 100% compliance is achieved, PI Committee will then monitor quarterly to assure continued compliance.** **1.Date of Completion: 10/23/11** ·A pain assessment was completed on 9/29/11 on resident (#9) and the resident was found to be pain free. ·A 100% audit of active residents PRN Pain Medication	

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	pain, or effectiveness of the medication for 6/8 and 6/15. There was no documentation to indicate the location of pain or the intensity of the pain for 6/22. The PRN MAR for July 2011, indicated there was an order for Tramadol (pain medication) to be given three times a day as needed for pain. The order further indicated staff was to document on the pain flow sheet. The record indicated Resident #9 had received the pain medication on 7/21/11 at 2:30 a.m. There was no documentation to indicate the location of the pain or the intensity of the pain. The PRN MAR for September 2011, indicated there was an order for acetaminophen to be given every four hours as needed for pain. The order further indicated staff was to document on the pain flow sheet. The record indicated Resident #9 had received the pain medication on 9/1/11 at 11:00 a.m., 9/5/11 at 7:00 a.m., and 9/5/11 at 10 (no am or p.m. listed). There was no documentation to indicate the location of the pain or the intensity of the pain. The current care plan for pain, dated 2/16/10, indicated "...assess location, frequency, duration and intensity of pain...document assessment...document		Administration Records will be completed by 10/23/11 by Nursing Administration and Pain Flow Sheets (LCAA – 525) have been implemented on 10/12/11 ·The form: Pain Flow Sheet (LCAA – 525) will be implemented every time a resident receives pain medication to assure documentation of location and intensity of pain and effectiveness of medication given is correct. - Licensed nursing personnel will be in-serviced by the Staff Development Coordinator by 10/23/11 on completing the Pain Flow Sheet. - Staff Development Coordinator will educate newly hired licensed personnel during orientation on completing the Pain Flow Sheet. ·Monitoring to ensure alleged deficient practice does not recur:	

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	effectiveness...." An interview was conducted with LPN #1 on 9/21/11 at 1:15 p.m. During the interview, she indicated the pain flow sheet is filed with the medication administration record (MAR). The record should be signed as given, what it was given for and its effectiveness. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure pain assessment follow up was completed for PRN meds as care planned for 1 of 3 residents reviewed for pain (Resident #9) in a sample of 6 residents who met the criteria for pain recognition and management . Findings include: The clinical record for Resident #9 was reviewed on 9/21/11 at 9:30 a.m.	F0309	**F309 Provide Care/Service for Highest Well Being** **- Health Information Manager will audit Medication Administration Record Books with monthly Medication Administration Record change out to ensure Pain Flow Sheets are placed in the Medication Administration Books. Residents that are started on as needed pain**	10/23/2011

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	Diagnoses included, but were not limited to, high blood pressure, above the knee amputation, muscle weakness and a history of joint replacement. The PRN (as needed) Medication Administration Record (MAR) for June 2011, indicated there was an order for acetaminophen (pain reliever) to be given every four hours as needed for pain. The order indicated staff was to document on the pain flow sheet. The MAR indicated Resident #9 had received the pain medication on 6/8/11 at 11:00 a.m. There was no documentation on the flow sheet to indicate the location of pain or the intensity of the pain. The PRN MAR for June 2011, indicated there was an order for ultram (pain reliever) to be given three times a day as needed for pain. The order further indicated staff was to document on the pain flow sheet. The record indicated Resident #9 had received the pain medication on 6/8/11 at 1:10 p.m., 6/15/11 at 1:55 p.m., and 6/22/11 at 11:00 a.m. There was no documentation regarding the location of pain, intensity of pain, or effectiveness of the medication for 6/8 and 6/15. There was no documentation to indicate the location of pain or the intensity of the pain for 6/22.		**medications within the month will be identified by physician's orders** **and the DON or designee will assure a Pain Flow Sheet is implemented.** **Twice weekly 100% audit of Pain Flow Sheets to ensure the forms are being utilized correctly.** **DON will review audits twice weekly and provide further education and/or disciplinary action as needed.** **- Findings will be brought to the PI Committee monthly with tracking** **and trending discussed. A goal of 100% compliance with correct** **utilization of the Pain Flow Sheet X90 days will be achieved. Once** **100% compliance is achieved PI Committee will then monitor quarterly to ensure continued compliance.** **5. Date of Completion: 10/23/11** ·A pain assessment was completed on resident (#9) on 9/29/11 and the resident was found to be pain free. ·A 100% audit of active residents PRN Pain Medication Administration Records will be completed by Nursing Administration by 10/23/11 and Pain Flow Sheets (LCAA – 525) will be implemented on 10/23/11 ·Systems to ensure alleged deficient practice does not recur:	

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	The PRN MAR for July 2011, indicated there was an order for Tramadol (pain medication) to be given three times a day as needed for pain. The order further indicated staff was to document on the pain flow sheet. The record indicated Resident #9 had received the pain medication on 7/21/11 at 2:30 a.m. There was no documentation to indicate the location of the pain or the intensity of the pain. The PRN MAR for September 2011, indicated there was an order for acetaminophen to be given every four hours as needed for pain. The order further indicated staff was to document on the pain flow sheet. The record indicated Resident #9 had received the pain medication on 9/1/11 at 11:00 a.m., 9/5/11 at 7:00 a.m., and 9/5/11 at 10 (no am or p.m. listed). There was no documentation to indicate the location of the pain or the intensity of the pain. The current care plan for pain, dated 2/16/10, indicated "...assess location, frequency, duration and intensity of pain...document assessment...document effectiveness...." The current policy titled "Pain Management Protocol," dated 3/2007, was provided by the Director of Nursing on		- The form: Pain Flow Sheet will be implemented every time a resident receives as needed pain medication to assure documentation of locations and intensity of pain and effectiveness of medication given is correct. - Licensed nursing personnel will be in-serviced by the Staff Development Coordinator on completing Pain Flow Sheet by 10/23/11. - Staff Development Coordinator will educate newly hired licensed personnel during orientation on completing the Pain Flow Sheet. ·Monitoring to ensure alleged deficient practice does not recur:	

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	9/23/11 at 9:10 a.m. The policy indicated "...nursing staff will monitor and document the effectiveness of pain management program in the resident medical record...each resident who has been identified to have pain will have their pain assessed at least once per shift to include vital signs...documentation of this assessment and vital signs will be placed on the Pain Flow Sheet...." An interview was conducted with LPN #1 on 9/21/11 at 1:15 p.m. During the interview, she indicated the pain flow sheet is filed with the medication administration record (MAR). The record should be signed as given, what it was given for and its effectiveness. 3.1-37(a)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview the facility failed to ensure 1 (resident #12) was provided an assistive device to prevent falls as care planned in a sample of 3 residents reviewed for falls in	F0323	**F 323 Free of Accident Hazards/Supervision/Devices- Findings will be brought to the PI Committee monthly withtracking and trending discussed. A goal of 100% compliancewith consistent**	10/11/2011

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	sample of 3 residents who met the criteria for falls, having the potential to affect 1 resident in the room. The facility further failed to ensure hot water temperatures in 3 of 10 resident room bathrooms observed for proper water temperatures were maintained between 100 and 120 degrees Fahrenheit (room 44, room 30, and room 111) having the potential to affect 3 residents (Resident ##71, Resident #13, and Resident #48). Finding includes: 1. Review of the clinical record for resident #12 on 9/21/11 at 10:00 a.m. indicated the resident had a fall on 9/11/11 at 5:00 p.m. Review of the incident indicated the resident was found on the floor in his bathroom, and had sustained redness to his back. The resident stated he tried to go to fast. Interview with the DON (Director of Nursing) on 9/21/11 at 10:30 a.m. indicated the resident had a personal alarm, but had improved (with therapy) and the alarm had been discontinued. The facility reinitiated the personal alarm at this time. Review of the clinical record indicated a care plan which indicated the resident was at risk for falls related to a history of falls,		**temperatures will be achieved. Once 100% compliance is achieved, PI Committee will then monitor quarterly to assure continued compliance.** **.5. Date of Completion: 10/11/11** ·Mixing valves replaced on two boilers 9/19/11.Water heater replaced on 9/26/11 on Preston Hall.- Flooring in bathroom of room for resident#12 was replaced on 9/26/11. Non skidstrips were applied on 9/23/11 and reappliedto new flooring ·An audit of non skid strips in relation to thecare guide was completed on 9/23/11 with nofurther issues noted.- Daily water temperature checks completed byMaintenance Director with no other fluctuationsnoted. ·Maintenance Director checks water temperaturesweekly with any deviations to approved temperaturesrelayed to the Executive Director and adjustments made.- Direct Care staff tests water before use on every occasionof resident need and any deviation from approved temperaturesis reported to the Maintenance Director and Executive Director.- Staff in-serviced by Maintenance Director on 10/11/11on reporting fluctuations in water temperatures and when to report to Maintenance and the Executive Director to ensure noresidents	

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	hemiplegia from a cerebral vascular accident (stroke) and decreased mobility. The goal was the resident would have limited injury from falls through September 2011. An intervention dated 6/21/11 was for the resident to have non-slip strips on the floor in front of the toilet. Observation of the resident's room on 9/21/11 at 11:00 a.m. revealed there were no non-slip strips in front of the toilet. The director of nursing was queried about the lack of floor strips, and called the maintenance supervisor to the resident's room. The Maintenance Director indicated there had been non-slip strips in front of the toilet but indicated the linoleum in the bathroom was "bad" and the strips did not always stick. Interview with resident #12 on 9/22/11 at 1:30 p.m. indicated there had been strips on the floor in the bathroom but indicated "they don't stick."		use water until safely regulated. ·Water temperature audits will be monitored weekly to assure temperatures are remaining consistent. ·Care guides are reviewed by Medical Records daily to ensure they match new and existing orders for assistive devices. Department Heads are assigned halls for daily review of the care guide to ensure assistive devices are in place. The Maintenance Director is responsible for ensuring assistive devices are moved to the new room when a resident is transferred. Assistive devices are also reviewed during care plan meetings quarterly or if a resident has a fall. The Fall Committee writes recommendations during their weekly meetings and assistive devices are written as orders and placed in the Work Order Book for the Maintenance Director or designee to install.	

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	2. On 9/19/11 at 12:30 P.M., during an observation of room 30, Resident #13's room, the temperature of the hot water in the hand washing sink in the bathroom felt very hot to the touch. A digital thermometer was then used to determine the actual temperature of the hot water. The digital thermometer registered a temperature of 128.4 degrees Fahrenheit. On 9/19/11 at 12:35 P.M., during an observation of room 111, Resident #48's room, the temperature of the hot water in the hand washing sink in the bathroom felt hot to the touch. A digital thermometer was then used to determine the actual temperature of the hot water. The digital thermometer registered a temperature of 130.1 degrees Fahrenheit.			

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	On 9/19/11 at 1:00 P.M., the hot water temperatures were checked in room 30 and room 111 by the facility maintenance director using a digital thermometer provided by the facility. The hot water in room 30 was 119 degrees Fahrenheit and the hot water temperature in room 111 was 119 degrees Fahrenheit. During an interview with the Maintenance Director, he indicated he had noted elevated water temperatures during a routine check and he had adjusted the water temperatures downward. On 9/19/11 at 2:30 P.M., during an observation of room 44, Resident # 71's room, the temperature of the hot water in the hand washing sink in the bathroom felt hot to the touch. The facility Maintenance Director checked the water temperature with a digital thermometer and noted that the hot water temperature was fluctuating between 134 and 138 degrees Fahrenheit. During an interview with the Maintenance Director, he indicated he thought that there might be a problem with the mixing valve, but he would attempt to adjust the water temperature down. He indicated facility staff were instructed not to use the hot water on the affected hallways. On 9/19/11 at 3:30 P.M., the facility			

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	Maintenance Director indicated a contracted plumber was scheduled to come to the facility later that day to check the mixing valves. 3.1-45(a)(1) 3.1-45(a)(2)			
F0412 SS=D	The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on record review and interview, the facility failed to obtain dental services for 1 of 3 residents reviewed for dental concerns (Resident #9) in a sample of 9 residents who met the criteria for dental status and services. Findings include: The clinical record for Resident #9 was reviewed on 9/21/11 at 9:30 a.m. Diagnoses included, but were not limited to, high blood pressure, above the knee amputation, muscle weakness and a	F0412	**F412 Routine/Emergency Dental Services in NFS** ·Resident (#9) was seen by the dentist on 9/22/11 and has no unmet dental needs. 2. PrimeSource dental services have been reinstated in facility effective 10/6/11. residents will be seen in-house by PrimeSource quarterly and as needed. 3. Social Services Director in conjunction with Nursing Administration will review dentist orders and physician orders Monday through Friday to ensure any resident identified to have a	10/06/2011

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	history of joint replacement. No notes were noted in the social services section of the chart regarding any concerns with obtaining a dentist. Nurse's notes dated 9/19/11 at 3:00 p.m., indicated Resident #9 "complained of discomfort while drinking cold fluids; states 'I feel a hole on the left side molar with my tongue'...called (physician's name documented) office, made appointment for 9/22/11. No other documentation was noted in the clinical record regarding the concern. The dental visit record, dated 4/12/11, indicated Resident #9 had inflammation and plaque. The note further indicated no prophy done, needs premed, next procedure with premed and schedule before 7/12/11. A nurse's note dated 4/12/11 at 10:20 p.m., indicated MD consult, possible med before cleaning at dentists visit due to knee joint replacement. A telephone order dated 4/12/11, indicated MD consult, premed order for dental visits if ok with physician, clindamycin 600 mg 1 hour before visit. An interview was conducted with Resident #9 on 9/12/11 at 11:00 a.m.		need is seen by the dentist as soon as possible. - Residents who complain of oral problems will be scheduled to see the PrimeSource dentist as soon as possible. - Social Services Director will review monthly dental visit list with PrimeSource personnel to ensure everyone is seen appopriately. 4. Social Services Director will audit resident medical record with care plan meetings and MDS schedule to ensure resident Dental needs are met X90 days. Weekly audits X4 then weekly X2 and then monthly. Findings will be brought to the PI Committee monthly with tracking and trending discussed. A goal of 100% compliance with meeting dental needs will be achieved. Once 100% compliance is achieved, PI Committee will then monitor quarterly to assure continued compliance. . 5. Date of Completion: 10/23/11	

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	During the interview, Resident #9 indicated the dentist was supposed to have cleaned her teeth in July. She stated there was a whole list of people that were to be seen in July but Medicaid insurance had changed so they weren't seen. She stated the residents would have to go out to the dentist, one that accepts Medicaid. An interview was conducted with the Staff Development Coordinator on 9/12/11 at 11:00 a.m. During the interview, she indicated there was nothing in the chart showing the premed had been followed up on. An interview was conducted with Social Services on 9/23/11 at 10:45 a.m. During the interview, Social Services indicated the contract for dental services was out the end of May. She further indicated the facility is now sending residents out to the dentist that accepts Medicaid. She stated they are currently using at least three different dentists and the facility is making appointments as they are needed. 3.1-24(a)(1) 3.1-24(a)(2) 3.1-24(a)(3)(b)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review the facility failed to accurately record attended activities of 1 of 3 sampled residents (Resident #67) reviewed for activities of the 10 residents who met the criteria for activities. The facility further failed to document release of restraint for 1 of 1 residents reviewed for restraint (Resident #23) in a sample of 1 residents who met the criteria for potential restraints. Findings include: 1. Review of the clinical record for Resident #67 on 9/21/11 at 9:25 a.m., indicated the following: diagnoses included, but were not limited to, Down's Syndrome and presenile delirium. A facility Activities Evaluation for Resident #67, dated 5/13/10, indicated current activity preferences of	F0514	**F514** **Records-Complete/Accurate/Accessible** ·Resident (#67) had medical record reviewed and corrected to reflect current status (10/3/11). ·Resident (#23) Restraint release is monitored by Licensed personnel daily and is now being recorded daily and documented on the resident's Medication Administration Record. 1.Activities Director or designee will audit 100% of participation logs weekly X4 then weekly X3 then weekly X2 and then monthly. Licensed personnel will audit 100% of restraint release documentation on the MAR weekly X4 then weekly X3 then weekly X2 and then monthly. 3. Activities Staff in-serviced on proper documentation of the participation logs on 10/5/11 by Executive Director. Licensed personnel will be	10/23/2011

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	155266	A. BUILDING 00 B. WING	09/23/2011

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	animals/pets, arts/crafts, beauty/barber, cards, community outings, educational programs, exercise, family/friend visits, group discussion, movies, music, radio, reading, religious services, religious studies, sing-along, social/parties, television, and walking. The Activity Director was interviewed on 9/22/11 at 1:56 p.m. During the interview he indicated activity staff were responsible for recording the attendance for Resident #67 on the Individual Resident Daily Participation Record. He further indicated the letter A meant active participation, the letter P meant passive participation, the letter R meant refused, and the letter U meant unable. A facility Activities Schedule for September 2011, provided by the Activity Director on 9/22/11 at 1:56 p.m., indicated the following: on 9/20/11, morning stretch at 9:30 a.m., music with (name documented) at 10:00 a.m., and Bingo at 3:00 p.m.; on 9/21/11, morning stretch at 9:30 a.m., trivia at 11:00 a.m., and dining room basketball at 1:30 p.m.; and 9/22/11, sensory group at 9:30 a.m., chapel at 10:00 a.m., and horseshoes at 2:00 p.m. A facility Individual Resident Daily Participation Record for Resident #67, for		in-serviced by SDC on 10/11/11 regarding appropriate documentation of the restraint records on MAR. 4. Activities documentation audit and restraint release audit will be included in PI meetings next 90 days. Findings will be brought to the PI Committee monthly with tracking and trending discussed. A goal of 100% compliance with meeting dental needs will be achieved. Once 100% compliance is achieved, PI Committee will then monitor quarterly to assure continued compliance. . Date of Completion: 10/23/11	

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	the month of September 2011, indicated she actively participated in current events/news on 9/20/11 and on 9/21/11, passively participated in exercise on 9/20/11, and passively participated in group discussion on 9/20/11 and 9/21/11. The Participation Record also indicated she actively participated in movies, music, radio, and television in her room on 9/20/11 and 9/21/11. The Participation Record did not indicate Resident #67 refused to attend music with (name documented) on 9/20/11 at 10:00 a.m., Bingo on 9/20/11 at 2:00 p.m., and trivia on 9/21/11 at 11:00 a.m. No entries had been made on the Participation Record for 9/22/11. Resident #67 was not observed attending any of the scheduled activities on: 9/20/11, morning stretch at 9:30 a.m., music with (name documented) at 10:00 a.m., and Bingo at 2:00 p.m.; 9/21/11, morning stretch at 9:30 a.m., and trivia at 11:00 a.m.; 9/22/11, sensory group at 9:30 a.m., Thursday Chapel at 10:00 a.m., and horseshoes at 2:00 p.m. Activity Assistant #2 was interviewed on 9/22/11 at 2:17 p.m. During the interview she indicated activity staff were responsible to bring the residents who required assistance with transportation to activities.			

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2. On 9/21/11 at 1:20 p.m., Resident #23 was observed in her room reading a magazine with a full lap tray in place on her wheelchair.

A telephone order for Resident #23, dated 12/14/10, indicated the resident was to be positioned in her wheelchair with a full lap tray for no more than 2 hours.

The current care plan for "At risk of injury d/t (due to) need for a chair that prevents rising," dated 12/30/1899 (sic), indicated the resident was to be assisted to change position every 30 minutes to 2 hours.

The September 2011 "Restraint Release Record," for Resident #23 was missing documentation on 9 of 16 days reviewed for 30 minute checks and/or release every two hours.

An interview was conducted with LPN #1 on 9/22/11 at 1:40 p.m. During the interview, LPN#1 indicated documentation for restraint release would be found in the book with Medication Administration Records (MAR). A review of the record indicated there was

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	no documentation with the MAR for release of the restraint. 3.1-50(a)(1) 3.1-50(a)(2)			